State of Connecticut
Department of Social Services

W-406
(Rev. 7/10)

Hospice Election

Effective Date of Hospice Election (mm/dd/yyyy):_____
(This form must be faxed to DSS on the first business day after election.)

*Client is eligible for (check one): ☐ Medicaid Only (HM) ☐ Medicaid and Medicare A (HD)

1. Client Information

Name:* _____
(first) (m.i.) (last)

Client ID Number:* _____

Address or other location (if not in private home):

_____
(number and street) (apt. number)

_____
(city) (state) (zip code)

Medicare Number:_____

Date of Birth:_____
(mm/dd/yyyy)

Sex: ☐ M ☐ F

Client Telephone Number:_____

Date of Physician's Certification of Terminal Illness:

_____

Primary Terminal Diagnosis (ICD-#):_____

Date of Terminal Diagnosis:_____
(mm/dd/yyyy)

Name of Parent, Legal Guardian or Representative

(if applicable)_____

2. Provider Information

* _____
Name of Hospice Provider

* _____
Medicaid Hospice Provider Number

_____
Hospice Telephone Number

_____
Medicaid Hospice Fax Number

_____
Name of Attending Physician Medicaid Provider Number

_____
Name of Contact at Hospice

3. Facility Information (if Applicable)

_____
Name of Nursing Facility or ICF/MR

_____
Facility Medicaid Provider Number

_____
Authorized Rep of Nursing Facility or ICF/MR

_____
Telephone Number

* **IF THIS INFORMATION IS MISSING OR INACCURATE, THE INFORMATION WILL NOT BE PROCESSED.**

Client ID Number:_____

4. Hospice Benefit Information

Check the appropriate current hospice benefit period below:

☐ 1st 90-day period ☐ 2nd 90-day period ☐ 1st 60-day period

☐ subsequent 60 day period e.g. 2, 3, 4 (specify):_____

5. Election Statement

If client has elected hospice under Medicare, the signed Medicare election statement may be attached in lieu of item #5, Connecticut's Hospice Election statement.

(a) The Connecticut Medicaid hospice benefit has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitation of this program and the terms of the election statement.

(b) If I am 21 years of age or older, I understand that by signing this election statement I waive all rights to regular Medicaid services except for payment to my attending physician and treatment for services unrelated to my terminal illness. If I am 20 years of age or younger, I may continue to receive curative treatment while I receive hospice services.

(c) I understand that I will be entitled to Medicaid hospice services as long as I am Medicaid eligible. The benefit will be provided in benefit periods of an initial 90 days, a subsequent 90 day period, and an unlimited number of successive 60 day periods.

(d) I understand that I may revoke the hospice benefit at any time by completing a Hospice Revocation Form, specifying the date when the revocation is to be effective and submitting the form to the hospice provider at the time of revocation. At the time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided that I continue to be Medicaid eligible; I understand that I may re-elect the hospice benefit at any time.

(e) I understand that I am eligible to receive hospice services only through the provider I have designated.

(f) I understand that I may change the designated hospice provider one time per election period without affecting the provision of my hospice benefit and that to do so my hospice provider is required to fill out a Change of Hospice Provider Form.

(g) I understand that if I am a Medicare recipient, I must elect to use the Medicare hospice benefit instead of the Medicaid benefit.

* _____ * _____

Signature of Client or Client Representative Date of Signature (mm/dd/yyyy)

Fax this form to the Central Processing Unit at DSS: (860) 424-5678.

* **IF THIS INFORMATION IS MISSING OR INACCURATE, THE INFORMATION WILL NOT BE PROCESSED.**

Instructions for Completion of Hospice Election form (W-406)

When a client has elected the hospice benefit under Medicaid, the Hospice Election form must be completed and faxed to DSS at (860) 424-5678 on the next business day after the election. The original Hospice Election form should be kept on file at the hospice agency.

If a client has elected hospice under Medicare, the Medicare election statement may be attached in lieu of Connecticut's Hospice Election Statement.

Beginning with the date of hospice election, the hospice is responsible for payment of all services related to the terminal illness and must educate clients and vendors/providers that these services must be arranged and paid for by the hospice agency.

For a client who is granted Medicaid eligibility retroactively, the election form must be faxed to DSS within two business days after eligibility has been granted.

If the client is eligible for Medicaid and not Medicare, check "Medicaid Only (HM)." If the client is eligible for both Medicaid and Medicare, check "Medicaid and Medicare (HD)."

For a client who is in a nursing facility or ICF/MR, the facility name and number must match the facility to which DSS has authorized admission. For a client eligible for Medicare, the Department will pay for room and board only for a client in a nursing facility or ICF/MR. All other charges associated with hospice election are the responsibility of the hospice agency.

By completing information on a nursing home or ICF/MR the hospice agency is certifying that it has an agreement with the nursing home or ICF/MR in accordance with Section 17b-262-841(c) of the Regulations of Connecticut State Agencies.

Do not fax this page to DSS.